

## HEALTHY HOMES UNIVERSITY PROGRAM APPLICATION

**Part I.** Please fill out the information below:

Renter	Homeowner
Name: _____	Name: _____
Address: _____ Apt. _____	Address: _____ Apt. _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
County: _____	County: _____
Home Phone: _____ Cell Phone: _____	Home Phone: _____ Cell Phone: _____

**Part II.** Please fill out the following information for each child under the age of 18 years who lives in the house:

**For Staff  
Use Only**

### Child 1

Name of child: _____ Your relationship to child: _____	
Date of birth: _____ Sex (M/F): _____ Race (Optional): _____	
Name and phone number of the legal guardian/parent of this child: _____	
Have you ever been told by a doctor or nurse that this child has asthma?	Yes No Don't Know
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes No Don't Know
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes No Don't Know
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes No Don't Know
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes No Don't Know
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes No Don't Know
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she <b>did not</b> have a cold or the flu?	Yes No Don't Know
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes No Don't Know
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes No Don't Know
Have you ever been told by a doctor or nurse that this child had eczema?	Yes No Don't Know
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes No Don't Know

For additional children, please complete reverse side of this sheet.

### Child 2

Name of child: _____ Your relationship to child: _____				
Date of birth: _____ Sex (M/F): _____ Race (Optional): _____				
Name and phone number of the legal guardian/parent of this child: _____				
Have you ever been told by a doctor or nurse that this child has asthma?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes	No	Don't Know	
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes	No	Don't Know	
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes	No	Don't Know	
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes	No	Don't Know	
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes	No	Don't Know	
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she <b>did not</b> have a cold or the flu?	Yes	No	Don't Know	
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had eczema?	Yes	No	Don't Know	
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes	No	Don't Know	

### Child 3

Name of child: _____ Your relationship to child: _____				
Date of birth: _____ Sex (M/F): _____ Race (Optional): _____				
Name and phone number of the legal guardian/parent of this child: _____				
Have you ever been told by a doctor or nurse that this child has asthma?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had reactive airway disease (RAD)?	Yes	No	Don't Know	
Has this child ever had episodes of wheezing (whistling in the chest) in the past 12 months?	Yes	No	Don't Know	
In the past 12 months, have you heard this child wheeze or cough during or after active play?	Yes	No	Don't Know	
Other than a cold, in the past 12 months, has this child had a dry cough at night?	Yes	No	Don't Know	
In the past 12 months, has this child been to a doctor, urgent-care, emergency room, or a hospital for wheezing?	Yes	No	Don't Know	
In the past 12 months, has this child had a problem with sneezing, or a runny, or blocked, or stuffy nose when he/she <b>did not</b> have a cold or the flu?	Yes	No	Don't Know	
In the past 12 months, has this nose problem been accompanied by itchy-watery eyes?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had hay fever?	Yes	No	Don't Know	
Have you ever been told by a doctor or nurse that this child had eczema?	Yes	No	Don't Know	
Has this child ever had an itchy rash which was coming and going for at least 6 months?	Yes	No	Don't Know	

**Part III.** Please answer the following questions by checking **Yes**, **No**, or **Don't Know**

	Yes	No	Don't Know	Staff Use Only
1. Does any occupant in the home have a disability? Explain: _____				
2. Is this a single parent/guardian household?				
3. Do you plan to move within the next 6 months?				
4. What is the ZIP Code of this home?	ZIP: _____			
5. Does anyone smoke in the home?				
6. Are there any other sources of smoke in the home? If yes, please circle: Gas Stove Wood Burning Stove Kerosene Heaters Fireplace Other _____				
7. Does the home have any pets such as dogs, cats, hamsters, birds, or other feathered or furry pets that spend time indoors?				
8. In the past 30 days, has anyone seen cockroaches in the home?				
9. In the past 30 days, has anyone seen evidence of mice, rats or other rodents in the home?				
10. In the past 30 days, has anyone seen or smelled mold or a musty odor inside the home? (Do not include mold on food.)				
11. Has a child in this home been injured and taken to the doctor or emergency? If yes, please circle type: Slip/Fall Burn Electric Shock Poisoning Chemical Burns Cut Other _____				
12. How did you hear about this program? Friend/Relative Hospital Doctor/Nurse Community Activity Government Agency Media Other _____				
13. What is the language(s) spoken in the home?				

**Part IV.** Please complete and attach copies.

1. What is the total yearly income of the household? Attach copies of last year's W2s or current pay stubs <b>and</b> proof of other income (i.e., disability, alimony, federal assistance, child support, etc.)	\$ _____	
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**Questions? Please call Linda Stewart, Assistant Project Coordinator at (517) 335-8867 or toll-free at (866) 691-5323.**

All medical information obtained for this program will be kept confidential in accordance with applicable State and Federal laws and guidelines. The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.

I verify that the answers provided above are true.

\_\_\_\_\_  
Name (Please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Mail completed application to:**

**Lead & Healthy Homes Section  
P.O. Box 30195  
Lansing, MI 48909**

**FOR STAFF USE ONLY**

DATE APPLICATION RECEIVED: _____	INITIALS: _____	INSPECTION/ASSESSMENT: ■ Yes ■ No	INITIALS: _____
DATE APPLICANT CONTACTED: _____	INITIALS: _____	BASIC INTERVENTION: ■ Yes ■ No	INITIALS: _____
DATE APPLICATION ENTERED INTO DATABASE: _____	INITIALS: _____	CUSTOM INTERVENTION: ■ Yes ■ No	INITIALS: _____
APPROVED PENDING VERIFICATION OF THE FOLLOWING: ■ INCOME ■ INCOMPLETE OR MISSING INFORMATION			